

Figure 1

Patient Description:	45 y/o male with TAA presenting on 7/20/02 with atypical chest pain
HPI:	Presented to Sentara Beach with c/o atypical CP. Dx. with TAA, 12.5cm x 6.9 x 2.7, involving the renal arteries. Cardiac clearance for OR by nuclear stress scan - nl LV fx, small area of apical ischemia
Source of Pt Info:	medical records
Pre-Admission Meds:	aspirin, other, other, other, other
Allergies:	Penicillin
Past History:	CVA/SC: HTN, hypercholesterolemia; PULM: COPD, asthma; GI: hernia repair x 2
Review of Systems:	CVA/SC: chest pain - atypical; PULM: denies COPD, denies bronchitis; ENDO: negative; MUSC: SKEL: negative
Social History:	Occupation: sales; married; ethanol use: rare; 20-40 pack years - still smoking; DRUG ABUSE: no
Family History:	CAD: father; cancer: sister has polycystic disease
Physical Exam:	HR: 62, sinus, with PACs; BP: 120/80; Tmax: 38.5; Resp: 20, stridorous; O2 sat: 92; FIO2: 60; PEEP: 20 CVP: 12; PAOP: 17; CO: 4.5; SVR: 1280 Healthy appearing; obese; not in acute distress NEURO: GCS: M: 6, V: 5, E: 4; mental status: sedated, agitated at times, attention x 3 Head/neck: pupils: equal, react to light; conjunctivae: normochemosis; ear: normal; mouth/pharynx: edentulous, small palatal erosion; neck: normal mobility, no tenderness, no JVD PULM: not intubated; clear to percussion; bibasilar rales CVA/SC: PMI: normal; S-1 normal, S-2 normal, no S-3, no S-4; no murmurs, ruburs; L carotid decreased GI: within normal limits EXTREM: perfusion: adequate
Test Results:	eggs - 9.2; Hct - 29, WBC - 13.9, Plt - 196, INR - 1.56, PTT - 58 Na - 134, K - 3.5, Cl - 103, HCO3 - 24, BUN - 22, Glu - 220, Ca - 8.2, Cr - 1.6, Retic - 4.4, Mg - 1.0, Albumin - 3.5, Total Protein - 40, AST (SGOT) - 22, ALT (SGPT) - 12, LDH - 98, Total Bilirubin - 2.2 Digoxin - 1.8, Theophylline - 12 pH - 7.36, PCO2 - 32, PO2 - 113, HCO3 - 19, vented, FiO2 - 50%, PEEP 5
Assessment and Plan:	
NEURO	Problems: encephalitis-viral (hyper)
CVA/SC	Problems: chest pain-atypical, aortic aneurysm, hypertension Treatment: beta-blocker, oxygen therapy (<40%) TAA - for OR Monday, on BNP and Ipratropium, needs beta-blocker recheck. Low risk coronary per nuclear scan. Active smoker w/ no known symptoms, flu CPR, bronchodilators prn. SGLT/DVT / GI prophylaxis / nutritional support

Figure 2

Microsoft Internet Explorer

Refresh Logout Change Password

Patient: 2411 MC Elected MRef: 22456720 Center: North General Hospital Age: 44 Gender: Male

Patient Profile	Vital Signs	Event Log	Laboratory	Imaging	Medications	Order Entry	Notes/Orders	Physician	Physician	The Bridge
Care Plan	Flowchart	Life Log	Microbiology	ABQ/Ment	Medication	Order View	Notes/View	Physician	Physician	

Create Admission Note

Was the patient admitted from the O.R. or went to O.R. within 4 hours of admission? ☐ No ☒ Yes

Admission Diagnosis

Organ System: Diagnosis:

Chief Complaint/History of Present Illness

pt was presented with 5/12/2016 after admission of abdominal pain at home. pt with known AAA - stable for the past 2 years.

Source of Patient Information:

Screen 1 of 10

Cancel ☒ YES ☐ NO ☐ UNKNOWN

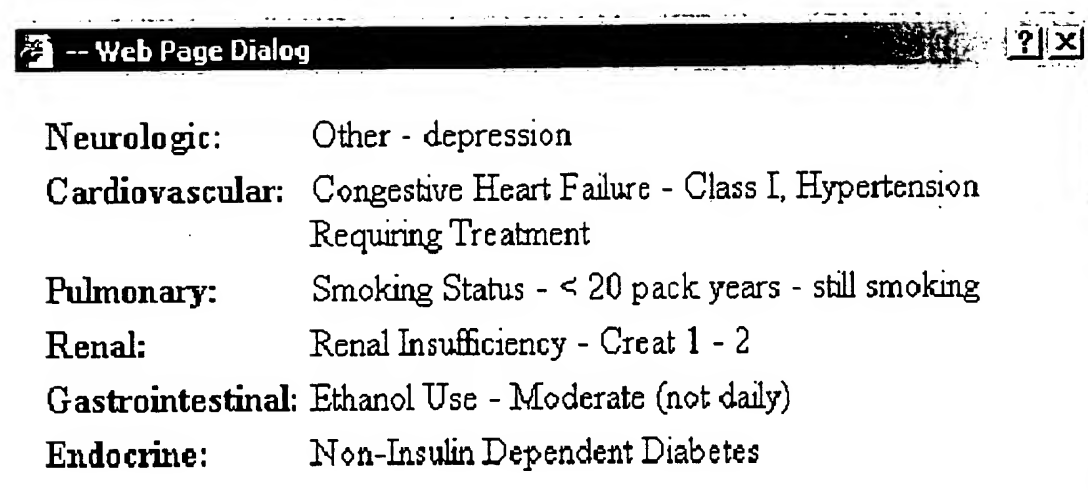
Figure 3

Figure 4

Figure 5

[illegible]

FIGURE 7

A screenshot of a web browser window titled "-- Web Page Dialog". The window contains a list of medical conditions organized by system. The conditions are: Neurologic: Other - depression; Cardiovascular: Congestive Heart Failure - Class I, Hypertension Requiring Treatment; Pulmonary: Smoking Status - < 20 pack years - still smoking; Renal: Renal Insufficiency - Creat 1 - 2; Gastrointestinal: Ethanol Use - Moderate (not daily); Endocrine: Non-Insulin Dependent Diabetes.

Neurologic:	Other - depression
Cardiovascular:	Congestive Heart Failure - Class I, Hypertension Requiring Treatment
Pulmonary:	Smoking Status - < 20 pack years - still smoking
Renal:	Renal Insufficiency - Creat 1 - 2
Gastrointestinal:	Ethanol Use - Moderate (not daily)
Endocrine:	Non-Insulin Dependent Diabetes

FIGURE 8

Patient Details		Referral		Task Log		Physician Reviewed		Location	
Date: 01/11/2001		Vital Signs: 10/10/2001		Referral: Initial Consultation		Physician: Dr. Smith		Location: Outpatient	
Physician Profile	Vital Signs	Event Log	Laboratory	Form ID	Medications	Order-Clinic	Order-Home	Key Images	The Source
Core Plan	Plan Sheet	Lab Log	Microbiology	ABQ West	Medications	Order-View	Order-View	View Reports	

Create Admission Note

Review Of Systems

☒ Performed ☐ Not Performed

General Systemic

Share Worksheet

Summary

1 - General Systemic

2 - Eye

3 - ENT

4 - Cardiovascular

5 - Respiratory

6 - Gastrointestinal

7 - Genitourinary

8 - Musculoskeletal

9 - Skin

10 - Neurologic

11 - Psychiatric

12 - Endocrine

13 - Hematologic

General Systemic

Weight Loss:

Fatigue:

Comments:

Eye

Blurred vision:

Double vision:

Eye pain:

Comments:

ENT

Hearing problems:

Tinnitus:

Comments:

Cardiovascular

Chest pain:

Palpitations:

Leg swelling:

Comments:

Respiratory

Shortness of breath:

Printed: 01/11/2001
Cancel
Printed: 01/11/2001

Web Page Dialog	
Cardiovascular	Leg swelling;
Neurologic	Loss of consciousness;
Psychiatric	Depression;

Patient Census	Refresh	Task List	Change Password	Logout
BT-4) Randall Cunningham		MR#321654687	VISICU : Guest Facility (-300 GINT) : GICU	Age: 38 Gender: Male

-#	+ #	Refresh Print	Inpatient Discharge	Update Medication	Lab History	Lab Orders	Med Orders	Med History	SOS History	Orders - Open	Orders - View	Nurses - View	View Source
		Care Plan	Event Log	Respiratory	Lice Log	I and O	Imaging						

Create Admission Note

Social History

☐ Performed ☐ Not Performed

Occupation:

Hobbies:

Marital Status:

Smoking Status:

Ethanol Use:

IV Drug Abuse:

Other Medic Drugs:

Recent Travel:

Comments:

Family History

☐ Performed ☐ Not Performed

CAD:

Cancer:

Bleeding Disorders:

Comments:

Screen 5 of 10

cc @mms.com
Cancel

● Indicates a required field.

Next >>

FIGURE 11

Physical Exam

Performed / Not Performed

Constitutional

Vital Sign Data

Noninvasive Mean:

Systemic Mean:

PA Mean:

Heart Rate:

Rhythm:

Temp (max):

Comments:

Appearance

General well-being:

Acute distress:

Nutritional status:

Comments:

Neurologic

GCS:

Motor Score:

Verbal Score:

Eyes Score:

Mental Status:

Level of consciousness:

Mood:

Orientation:

Comments:

Physical Exam Summary

1 - Constitutional

2 - Neurologic

3 - Eye

4 - Ear/Nose/Mouth/Throat

5 - Neck

6 - Respiratory

7 - Cardiovascular

8 - Reflexes/Hemodynamic Data

9 - Extremities

10 - Skin

Previous

Cancel

Next

FIGURE 12

Organ System	Organ System
<ul style="list-style-type: none"> • Nervous • Endocrine • Circulatory • Respiratory • Skin • Musculoskeletal • Integumentary • Urinary • Reproductive • Digestive • Excretory • Immune 	<ul style="list-style-type: none"> • Nervous • Endocrine • Circulatory • Respiratory • Skin • Musculoskeletal • Integumentary • Urinary • Reproductive • Digestive • Excretory • Immune
Today's problems diagnoses:	Today's treatments diagnostics:
<div> <input type="button" value="Check All"/> <input type="button" value="Remove Unchecked"/> </div> <div> <input type="button" value="Check All"/> <input type="button" value="Remove Unchecked"/> </div>	
<div> <input type="button" value="Previous"/> <input type="button" value="Cancel"/> <input type="button" value="Next"/> </div>	

FIGURE 13

Emergency Room Management

Return Task Log Cancel Printout Logout

MRN: MF00476799 To: Dr. J. D. F. Patient Number: 0011 4/11/01 09:30 AM

Patient Profile	Vital Signs	Event Log	Laboratory	Test O	Medications	Orders-Cases	Admission	Key-Info	The Source
Case Plan	Roomsheet	Lab Log	Microbiology	ABQ/Met	Mediupdate	Orders View	A. Notes View	Key Reports	

Create Admission Note

Laboratory Results To Print:

☒ Chemistry ☐ ABQ ☒ CBC & Coagulation ☐ Drug Levels ☒ Cardiac/Metabolic Levels

Assessment and Plan:

Patient appears to be moderately agitated/dehydrated. With laboratory results and plan rapid changes. Patient's pulse per minute 100 bpm.

Screen 3 of 10

as [button] Cancel Next >>

● indicates a required field

-37-

Create Admission Note

Billing Information:

Include billing information? ☐ Yes ☒ No

Complexity of decision making: ☐ Low ☒ Moderate ☐ High

Time devoted to care: : :

Do you want to include the following text in your note? ☒ Yes ☐ No

Care during the admission. History was provided which included a review of the patient's available data including medical history, records of past surgical findings, physical examination, laboratory and radiographic test results, arterial blood gas values, chest x-rays and other radiographic studies and electrocardiograms as part of my evaluation.

Print >>

FIGURE 15

[illegible]

FIGURE 16

Patent Chart - Microsoft Internet Explorer

Refresh Task List Change Patient Legend

2411 ME Everett I.F.# 123456789 Set LRA (Admit) Current H... ICU Age 44 Get Out Map

Patient Profile	Vital Signs	Event Log	Laboratory	Isand D	Medications	Orders/Charts	Phys. Orders	Notes/Reports	The Route
Care Plan	Flowchart	Line Log	Medication	ABC/Med	Medication	Orders/View	Phys. Orders	Notes/Reports	

Create Re-Admission Note

Reason for Readmission? ●

Was the patient admitted from the O.R. or went to O.R. within 4 hours of admission? ●

- Admitting Diagnoses

Organ System ● Diagnosis ●

Chief Complaint/History of Present Illness:

At 90 min 510 recent ruptured AAA repair that included catheter to OP for drainage of hematoma. Over past several days, has developed fever, cough and purulent sputum, CXR reveals PML infiltrate and brought to ICU for increasing respiratory distress.

Source of Patient Information ●

Screen 1 of 10

Cancel

● indicates a required field

Next >>

FIGURE 17

Patient Chart		Referral		Task List		Change Password		Logout																																																	
<table border="1"> <tr> <td>ADT</td> <td>Medication</td> <td>Lab</td> <td>Lab</td> <td>Lab</td> <td>Lab</td> <td>Lab</td> <td>Lab</td> <td>Lab</td> <td>Lab</td> </tr> <tr> <td>Patient Profile</td> <td>Vital Signs</td> <td>Event Log</td> <td>Laboratory</td> <td>Lab O</td> <td>Medication</td> <td>Orders-Create</td> <td>Orders-View</td> <td>Physician</td> <td>Physician</td> </tr> <tr> <td>Case Plan</td> <td>Physician</td> <td>Unit Log</td> <td>Microbiology</td> <td>ABX/Int</td> <td>Medication</td> <td>Orders-View</td> <td>Notes-View</td> <td>Physician</td> <td>The Source</td> </tr> </table>	ADT	Medication	Lab	Lab	Lab	Lab	Lab	Lab	Lab	Lab	Patient Profile	Vital Signs	Event Log	Laboratory	Lab O	Medication	Orders-Create	Orders-View	Physician	Physician	Case Plan	Physician	Unit Log	Microbiology	ABX/Int	Medication	Orders-View	Notes-View	Physician	The Source	<h3>Create Re-Admission Note</h3> <p>Reason for Readmission? <input type="radio"/> New admission <input checked="" type="radio"/> Elective</p> <p>Was the patient admitted from the O.R. or went to O.R. within 4 hours of admission? <input type="radio"/> Yes <input checked="" type="radio"/> Elective</p> <p>Surgical Diagnosis: _____</p> <p>Organ System: <input type="radio"/> Cardiovascular <input checked="" type="radio"/> Diagnostics (SACG score, coronary artery bypass grafting)</p> <p>Post-Operative Status: _____</p> <p>Anesthesia: <input type="radio"/> General <input checked="" type="radio"/> EBL (ml) 500</p> <p>Complications:</p> <table border="1"> <tr> <td><input type="checkbox"/> Cardiac Arrest</td> <td><input type="checkbox"/> Hypotension</td> <td><input checked="" type="checkbox"/> Myocardial Ischemia</td> </tr> <tr> <td><input type="checkbox"/> Cerebral Ischemia</td> <td><input type="checkbox"/> Myocardial Hemorrhage</td> <td><input type="checkbox"/> Prolonged Hypertension</td> </tr> </table> <p>Fluids:</p> <table border="1"> <tr> <td>Cell Saver (ml)</td> <td>0</td> <td>FFF (units)</td> <td>0</td> </tr> <tr> <td>Colloid (ml)</td> <td>500</td> <td>Platelets (units)</td> <td>0</td> </tr> <tr> <td>Crystalloid (ml)</td> <td>1500</td> <td>SFEC (units)</td> <td>0</td> </tr> </table> <p>Chief Complaint/History of Present Illness:</p> <p>At 10:00 AM, the patient reported chest pain that included pressure to the chest for several days. The patient developed chest pain associated with tachycardia. ECG changes: cardiac data revealed severe triple vessel disease and patient received 3 vessel CABG. The patient was stable for the remainder of the procedure. During anesthesia induction, the patient developed a hypotensive episode and was stabilized with the administration of atropine and beta blockers.</p> <p>Source of Patient Information: <input type="radio"/> Medical Record <input checked="" type="radio"/> _____</p> <p>Screen 1 of 10</p> <p>Cancel</p> <p>Print (Ctrl+P)</p> <p>Next >></p>									<input type="checkbox"/> Cardiac Arrest	<input type="checkbox"/> Hypotension	<input checked="" type="checkbox"/> Myocardial Ischemia	<input type="checkbox"/> Cerebral Ischemia	<input type="checkbox"/> Myocardial Hemorrhage	<input type="checkbox"/> Prolonged Hypertension	Cell Saver (ml)	0	FFF (units)	0	Colloid (ml)	500	Platelets (units)	0	Crystalloid (ml)	1500	SFEC (units)	0
ADT	Medication	Lab	Lab	Lab	Lab	Lab	Lab	Lab	Lab																																																
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Colloid (ml)	500	Platelets (units)	0																																																						
Crystalloid (ml)	1500	SFEC (units)	0																																																						

FIGURE 18

Has the patient had surgery since the last progress Note? ☐ No ☒ Yes

Events of Note:

FIGURE 19

Create Comprehensive Progress Note

Has the patient had surgery since the last progress note? ☒ Yes ☐ No

Surgical Diagnosis _____

Organ System ☒ Diagnoses

Post-Operative Status: _____

Axess/Assess/Consent ☒ EOL (no/m)

Complications:

<input type="checkbox"/> Cardiac Arrest	<input type="checkbox"/> Pulmonary	<input type="checkbox"/> Myocardial Infarction
<input type="checkbox"/> Difficult Intubation	<input type="checkbox"/> Massive Hemorrhage	<input type="checkbox"/> Prolonged Hypotension

Fluids:

Cat Enzyme (mL)	1	FFP (units)	0
Cat (mL)	1	PCC (units)	0
CryStat (unit)	0	LRPC (units)	0

Events of Note:

Patient started to develop moderate hypotension and increased abdominal distention with oliguria and was brought back to operating room for re-exploration which revealed a hematoma due to a small leak at the graft anastomosis. It remained in stable condition to the ICU.

FIGURE 20

Patient Census		Refresh		Task List		Change Password		Logout	
MD Eresheim		MR#123456789		Santara, Norfolk General Hospital		App 44		Order High	
Patient Profile	Vital Signs	Event Log	Laboratory	I and O	Medication	Orders-Creat	Physiologic	X-ray Images	The Source
Core Plan	Flowchart	Line Log	Microbiology	ABQ/Vent	Mediupdate	Orders-New	Handoff-Mat	X-ray Reports	

Create Brief Progress Note

Santara
Norfolk General Hospital
MR# 123456789

Events of Note:

Labs conducted on smart alert, moderate hypotension then noted on vital signs review as well as a decrease in CVP. By bedside examination, patient is in no distress, most recent electrolytes are normal, case discussed with ICU RN and will administer a bolus of 500 ml's normal saline and reassess

Brief Progress Note
PERMANENT
3/1/2002 3:33

Electronically signed by

FIGURE 21

Medical chart - [Patient Name] - [Room Number]

Buttons: Refresh, Print, [Other Icons]

Home	At the Bed	What's New	Lab Data	Orders	Medications	Diagnosis	History	Immunizations	Referrals	Other
Patient Profile	Vital Signs	Event Log	Laboratory	Lab Orders	Medications	Diagnosis	History	Immunizations	Referrals	Other
Core Files	Flowchart	Use Log	Microbiology	ABQ/Med	Medication	Diagnosis View	History View	Immunization	Referrals	Other

Create Procedure Note

Procedure: Catheterization Type of catheter: Arterial

- Arterial
- Central Venous
- Peripherally Inserted Central Catheter
- Other

Cancel

FIGURE 22

[illegible]

FIGURE 23

Create Procedure Note

Patient Care	Referral	Track List	Change Password	Logout
3411 VSD Cath - U	Vital Signs	Laboratory	Imaging	Orders/Reports
Patient Profile	Vital Signs	Laboratory	Imaging	Orders/Reports
Care Plan	Flowchart	Ureteral	ABG/Vent	Meds Update
			Orders View	Nurse View
			Physician	Signatures
			The System	

Sent to:
North Central Hospital
MR: Burchill MR 12-045780

Procedure: Central venous catheter insertion

Description of Procedure: multiple lumen antithrombotic bonded coated central venous catheter inserted into left subclavian vein for assessment of intravascular volume. No PICC line inserted. Procedure performed with gown and sterile technique. Local anesthesia administered. Seldinger technique used, blood flow good, CXR normal. CVC No apparent complications.

Electronically signed by _____

FIGURE 24

[illegible]

Table 1

Chemistries	ABG	CBC and Coagulation	Drug Level	Cardiac/Metabolic Levels
Na	pH	Hgb	NAPA (mcg/mL)	CPK (U/L)
Cl	PCO2	WBC	Tacrolimus-FK506 (ng/mL)	CPK-MB (%)
BUN	PO2	INR	Acetaminophen (mcg/mL)	CPK-MB (U/L)
Glu	HCO3	Hct	Amikacin (mcg/mL)	TSH (uU/mL)
Ca	RO2	Plts	Carbamazepine (mcg/mL)	Ammonia (uM/L)
K	PEEP	PTT ratio	Cyclosporin (ng/mL)	Cortisol (mcg/dL)
HCO3			Digoxin (ng/mL)	Ketones
Cr			Gentamicin (mcg/mL)	Osmolality (mOsm/kg H2O)
Phos			Lidocaine (mcg/mL)	Triglycerides (mg/dL)
Mg			Lithium (mEq/L)	Troponin - I (mcg/L)
Albumin			Phenobarbital (mcg/mL)	Troponin - T (mcg/L)
Total Protein			Phenytoin (mcg/mL)	
AST (SGOT)			Procainamide (mcg/mL)	
ALT (SGPT)			Theophylline (mcg/mL)	
LDH			Tobramycin (mcg/mL)	
Total Bilirubin			Vancomycin (mcg/mL)	
Direct Bilirubin				
Amylase			Tacrolimus-FK506 (ng/mL)	
Lactate			Acetaminophen (mcg/mL)	
Alkaline Phos				